maintaining optimal levels of physical and psychosocial functioning.

(ii) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each inpatient's active treatment program.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39820, Sept. 1, 1992; 59 FR 45397, 45400, Sept. 1, 1994; 69 FR 66976, Nov. 15, 2004; 71 FR 27086, May 9, 2006]

### § 412.29 Excluded rehabilitation units: Additional requirements.

In order to be excluded from the prospective payment systems described in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(3), a rehabilitation unit must meet the following requirements:

(a) Have met either the requirements for—

(1) New units under § 412.30(a); or

(2) Converted units under § 412.30(c).

(b) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program.

(c) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.

(d) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.

(e) Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least once per week to determine the appropriateness of treatment.

(f) Have a director of rehabilitation who—

(1) Provides services to the unit and to its inpatients for at least 20 hours per week;

(2) Is a doctor of medicine or osteopathy;

(3) Is licensed under State law to practice medicine or surgery; and

(4) Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39821, Sept. 1, 1992; 59 FR 45397, 45400, Sept. 1, 1994; 60 FR 45847, Sept. 1, 1995; 66 FR 41387, Aug. 7, 2001; 68 FR 45699, Aug. 1, 2003; 69 FR 66976, Nov. 15, 2004; 74 FR 39810, August 7, 2009]

### § 412.30 Exclusion of new rehabilitation units and expansion of units already excluded.

(a) *Bed capacity in units.* A decrease in bed capacity must remain in effect for at least a full 12-month cost reporting period before an equal or lesser number of beds can be added to the hospital's licensure and certification and considered ''new'' under paragraph (b) of this section. Thus, when a hospital seeks to establish a new unit under the criteria under paragraph (b) of this section, or to enlarge an existing unit under the criteria under paragraph (d) of this section, the regional office will review its records on the facility to determine whether any beds have been delicensed and decertified during the 12-month cost reporting period before the period for which the hospital seeks to add the beds. To the extent bed capacity was removed from the hospital's licensure and certification during that period, that amount of bed capacity may not be considered ''new'' under paragraph (b) of this section.

(b) *New units.* (1) A hospital unit is considered a new unit if the hospital—

(i) Has not previously sought exclusion for any rehabilitation unit; and

(ii) Has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds in the unit.

(2) A hospital that seeks exclusion of a new rehabilitation unit may provide a written certification that the inpatient population the hospital intends the unit to serve meets the requirements of § 412.23(b)(2) instead of showing that the unit has treated such a population during the hospital's most recent cost reporting period.

(3) The written certification described in paragraph (b)(2) of this section is effective for the first full cost reporting period during which the unit is used to provide hospital inpatient care.

(4) If a hospital that has not previously participated in the Medicare program seeks exclusion of a rehabilitation unit, it may designate certain beds as a new rehabilitation unit for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital. The written certification described in paragraph (b)(2) of this section also is effective for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(5) A hospital that has undergone a change of ownership or leasing as defined in § 489.18 of this chapter is not considered to have participated previously in the Medicare program.

(c) *Converted units.* A hospital unit is considered a converted unit if it does not qualify as a new unit under paragraph (a) of this section. A converted unit must have treated, for the hospital's most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the fiscal intermediary), an inpatient population meeting the requirements of § 412.23(b)(2).

(d) *Expansion of excluded rehabilitation units*—(1) *New bed capacity.* The beds that a hospital seeks to add to its excluded rehabilitation unit are considered new beds only if—

(i) The hospital's State-licensed and Medicare-certified bed capacity increases at the start of the cost reporting period for which the hospital seeks to increase the size of its excluded rehabilitation unit, or at any time after the start of the preceding cost reporting period; and

(ii) The hospital has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds it seeks to add to the unit.

(2) *Conversion of existing bed capacity.* (i) Bed capacity is considered to be existing bed capacity if it does not meet the definition of new bed capacity under paragraph (d)(1) of this section.

(ii) A hospital may increase the size of its excluded rehabilitation unit through the conversion of existing bed capacity only if it shows that, for the hospital's most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the fiscal intermediary), the beds have been used to treat an inpatient population meeting the requirements of § 412.23(b)(2).

(e) *Retroactive adjustments for certain units.* For cost reporting periods beginning on or after October 1, 1991, if a hospital has a new rehabilitation unit excluded from the prospective payment systems for a cost reporting period under paragraph (a) of this section or expands an existing rehabilitation unit under paragraph (c) of this section, but the inpatient population actually treated in the new unit or the beds added to the existing unit during that cost reporting period does not meet the requirements in § 412.23(b)(2), CMS adjusts payments to the hospital retroactively in accordance with the provisions in § 412.130 of this part.

[50 FR 12741, Mar. 29, 1985, as amended at 56 FR 43420, Aug. 30, 1991; 57 FR 39821, Sept. 1, 1992; 59 FR 45400, Sept. 1, 1994; 60 FR 45847, Sept. 1, 1995; 62 FR 46027, Aug. 29, 1997; 68 FR 45699, Aug. 1, 2003; 69 FR 25776, May 7, 2004]

## Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

### § 412.40 General requirements.

(a) A hospital must meet the conditions of this subpart to receive payment under the prospective payment systems for inpatient hospital services furnished to Medicare beneficiaries.